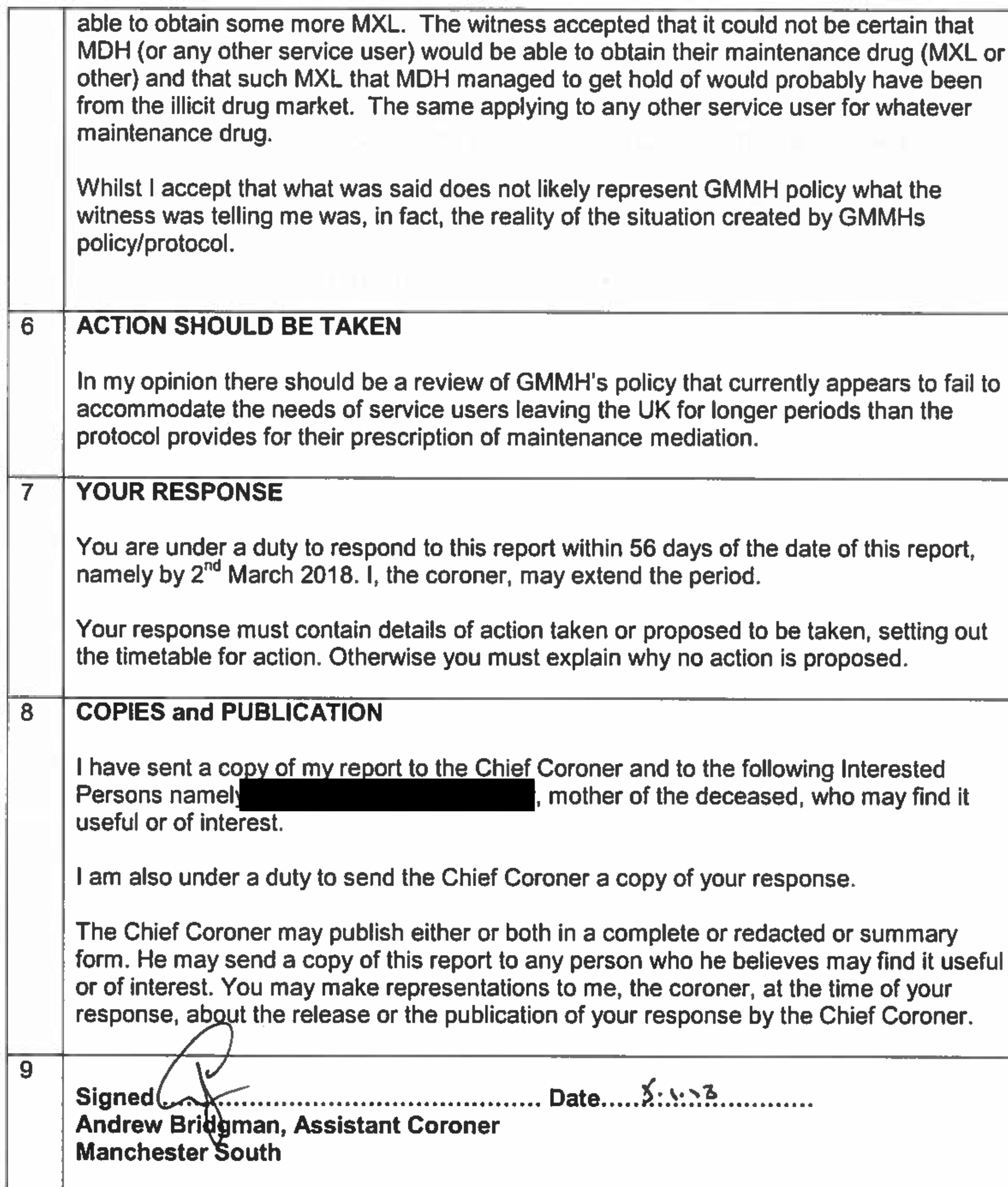
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Ms Bev Humphries, Chief Executive, Greater Manchester Mental Health NHS Foundation Trust, Trust Headquarters, Bury New Road, Prestwich, Manchester M25 3BL
1	**CORONER** I am Andrew Bridgman, Assistant Coroner, for the coroner area of South Manchester
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On 12th July 2017 I commenced an investigation into the death of one Marcus Dale Hamilton ("MDH"). The investigation concluded on the 27th October 2017. The medical cause of death was; 1a) Drug toxicity and the conclusion was; Drug related
4	**CIRCUMSTANCES OF THE DEATH** MDH was a long-term service user of the Trafford Drug Treatment Services, over 20 years. MDH's death was caused by the combined respiratory depressive effects of a number of drugs taken in slight excess and at such levels that none of them alone would have given rise to a fatality. There was no evidence of deliberate intent.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence gave rise to a matter which caused me concern, and from which I am of the view there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: For a number of years MDH was on a maintenance programme with MXL, which he received on a 28 days prescription. In December 2015 MDH informed GMMH that he was taking a long trip of 51 days, to Goa, India. MDH was advised that he could only have a 28 day prescription of MXL to take with him. He was only given a 28 day prescription along with the necessary documentation for travelling with the drug. In discussion with the witness from GMMH (MDH's Recovery Worker) regarding the fact that MDH would clearly run out of his prescription maintenance MXL part way through his holiday the answer I received was that there were drugs in India and MDH would be



	able to obtain some more MXL. The witness accepted that it could not be certain that MDH (or any other service user) would be able to obtain their maintenance drug (MXL or other) and that such MXL that MDH managed to get hold of would probably have been from the illicit drug market. The same applying to any other service user for whatever maintenance drug. Whilst I accept that what was said does not likely represent GMMH policy what the witness was telling me was, in fact, the reality of the situation created by GMMHs policy/protocol.
6	**ACTION SHOULD BE TAKEN** In my opinion there should be a review of GMMH's policy that currently appears to fail to accommodate the needs of service users leaving the UK for longer periods than the protocol provides for their prescription of maintenance mediation.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 2nd March 2018. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely [redacted], mother of the deceased, who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**Signed**.. **Date**.....5.1.18............ **Andrew Bridgman, Assistant Coroner** **Manchester South**